Cherry Street Health Services

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Written comments for the Health Policy Committee
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Chairwoman Haines and Members of the Committee:

This testimony is presented in response to HB NO. 4862 and HB NO.4863, the intent of which is to move statutory requirements of the section of the Public Health Code currently administered through sub-state regional entities identified as "Substance Abuse Coordinating Agencies", to the regional Prepaid Inpatient Health Plans (PIHP).

I want to join in thanking Representative Poleski for his efforts in bringing forward these bills. He was very open to inviting and accepting provider comments and concerns.

I am Michael Reagan, Chief External Relations Officer for Cherry Street Services, Inc., a Federally Qualified Health Center in Kent County that provides primary care, dental, vision, and services for persons with mental illness and substance use disorders. This full continuum of health care services is the result of a merger of three non-profit organizations joining efforts to provide better and more cost effective care to a most vulnerable and diverse population. This past fall, these three organizations merged and launched a specialized clinic that fully integrates care for persons with multiple chronic conditions, including serious to moderate mental illness, substance use disorders, and other medical chronic conditions. I have chosen to introduce my testimony with this background so that you understand a perspective that supports the integration of what has historically been called "behavioral health problems (mental illness and substance use disorders)" and primary medical and oral health care. As a provider, we are members of the Provider Alliance, an affiliate organization of the Michigan Association of CMH Boards. Conceptually, my organization supports this movement of the coordination of substance use disorder prevention and treatment services as described in the bill as long as its implementation is consistent with the following principles.

General Principles

- Substance use disorder treatment and prevention are a specialty discipline and practice of health care with accepted diagnosis, risk factors, evidence based practices for assessment, interventions, treatment and continuing care and recovery. And as such any structure for the coordination of planning, access and delivery should reflect this specialization.
- The effective prevention and treatment of substance use disorders must attend to the multiple risk factors for prevention of misuse, abuse and relapse and the

multiple needs of the individual either directly caused or compounded by the co-occurring disorders. Such co-occurring conditions include legal, medical, social, vocational, cognitive and emotional problems, and mental illnesses.

- The most effective treatment of substance use disorders requires ready access and placement in a treatment program appropriate to the particular needs of the individual. Also, remaining in treatment for an adequate time is critical for treatment effectiveness in accordance with ASAM accepted patient criteria and evidence based practices.
- Eligibility for publicly funded treatment services requires means testing and diagnostic placement in treatment in accordance with ASAM placement criteria.
- The State of Michigan should require master contract expectations for continuum of care, credentialing, treatment and prevention service specifications, treatment and prevention services and administrative audits, so as to gain efficiency and consistency in quality of services and accountabilities.
- Persons with substance use disorders and co-occurring mental illnesses, including a diagnosis of moderate to severe and persistent, should have access to a program that offers and provides both substance use and mental health treatment in an integrated manner as evidenced by staffing core competencies, services and program content. The treatment of co-occurring substance use disorders and mental illnesses is based upon the needs of individuals determined through an assessment process to have a primary substance use and mental health disorder. Services are to be provided through one service setting and through a single treatment plan, and represent appropriate clinical standards, including stage-matched interventions.
- While there is a significant prevalence of co-occurring serious and persistent mental illness and substance use disorders, it is also critically important that the system continue to provide access to the equally significant prevalence of persons with only primary substance use disorders.
- It is equally important that this integration recognizes that co-occurring mental illness and substance use disorders include a significant number of persons who have a diagnosed mental illness which does not reach the level of severity for the threshold of disability. Therefore if they are not otherwise eligible for Medicaid and Medicare because of a disability, they often present for treatment without insurance. This co-occurring mental illness also requires integrated care, including, in many cases, psychiatric medication. The integration of these services needs to begin to respond to this highly underserved population, who without insurance or very limited insurance coverage, only has access to care through public funds. Because of the reduction in general fund support to both mental illness and substance use disorders, this will remain a highly underserved population whose untreated health care will result in other health care, work, and family problems.

Structural Principles

- There is a need for a regional entity to coordinate publicly funded substance use disorder services, the structure and placement of which allows for the most efficient and effective coordination of access and engagement in treatment for persons needing care for substance use disorders alone, for substance use disorders and co-occurring mental illnesses, for substance use disorders and other co-occurring conditions such as other health problems, and/or legal criminal justice involvement etc. It is most important that this structure recognizes the specialty services integrity of the prevention and treatment of substance use disorders.
- Wherever possible, the regional configuration for the coordination of substance use disorder services should be coterminous with PIHP, and increasingly these PIHPs should be coterminous with primary health care regional areas.
- This regional coordination should allow for continuity of care for eligible individuals and appropriate care between funding systems when the individual's eligibility status changes or place of residence changes.
- Each regional structure is expected to provide a full continuum of prevention services, such community based prevention for the at-risk population and the general population.
- Each regional structure is expected to provide the following continuum for treatment services: screening, early intervention and assessment, outpatient, intensive outpatient, detoxification, short and long term residential, medication assisted treatment, recovery support, and to establish referral access to crisis stabilization, psychiatric evaluation, medication management, medical services, and transitional housing.
- Each regional structure is expected to adopt uniform contracting standards, which are shared statewide, to achieve administrative efficiencies and consistency. This is especially important for providers who provide regional specialized care and contact with multiple regional PIHPs. This would reduce unnecessary variations in contract expectations, would allow reciprocity in training, and would reduce audit expenses without compromising accountability or risk management. This would also eliminate inconsistent services definitions and variations which not only create additional administrative requirements for providers but create sometimes significant regional disparities in access to the full continuum of services.
- Finally, there is a concern that because of the fast track on which these bills appear to be headed, there is no time to look at the language which has been imported apparently verbatim from the Public Health Code. When the statutory language of the Public Health Code was composed, it reflected our understanding of substance use disorders at that time. The language shows its age and some of it is archaic, such as calling persons with a substance use disorder "an abuser" (in Section 100d. (12) (B)). The language does not reflect the scientific advances, particularly in the neurosciences, in our understanding of substance use disorders. It appears that the language could have been improved to reflect that this is a disorder that affects brain functioning and resulting harmful behavioral. I am

suggesting that in due course, if the bills are quickly adopted, that this language be carefully reviewed, and where appropriate, be changed through subsequent amendment to reflect current scientific understanding of substance use disorders as brain disorders.

In conclusion, I am supportive of the integration of the administration of substance use disorders within the PIHP regional structures.